Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

# Report of an inspection of a Designated Centre for Older People.

# Issued by the Chief Inspector

| | |
|---|---|
| Name of designated centre: | CareChoice Clonakilty |
| Name of provider: | CareChoice Clonakilty Limited |
| Address of centre: | Clogheen, Clonakilty, Cork |
| Type of inspection: | Unannounced |
| Date of inspection: | 04 March 2025 |
| Centre ID: | OSV-0000230 |
| Fieldwork ID: | MON-0046587 |

## About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

CareChoice Clonakilty is a designated centre for older people which is registered for the care of 50 residents. The premises is a purpose-built centre with three wings which are all on ground level. Residents are accommodated in 42 single bedrooms and four twin-bedded rooms. All bedrooms have en suite toilet, wash hand-basin and shower facilities. In addition, there are six assisted toilets and one assisted spa relaxation bathroom.Communal rooms include two dining rooms, two day rooms, a sensory room and a hair salon. The centre provides residential care predominately to people over the age of 65 but also caters for younger people over the age of 18. It is a mixed gender facility catering from low dependency to maximum dependency needs. It offers care to long-term residents and to short-term residents requiring transitional, convalescent and respite care.

**The following information outlines some additional data on this centre.**

| | |
|---|---|
| Number of residents on the date of inspection: | 47 |

## How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

**1. Capacity and capability of the service:**

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

**2. Quality and safety of the service:**

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

**This inspection was carried out during the following times:**

| Date | Times of Inspection | Inspector | Role |
|---|---|---|---|
| Tuesday 4 March 2025 | 09:30hrs to 17:30hrs | Ella Ferriter | Lead |

## What residents told us and what inspectors observed

Residents living in Carechoice Clonakility gave positive feedback with regard to their lived experience in the centre. Residents told the inspector that they received good care from a team of staff who were kind and respectful and they felt that staff supported them to enjoy a good quality of life. The inspector met and greeted with the majority of residents in the centre and spoke with eight residents, in more detail, about their experience of living in the centre. Some residents were unable to articulate their experience of living in the centre and the inspector observed that those residents appeared comfortable, relaxed and content in their environment and in the company of staff and other residents.

The inspector arrived to the centre unannounced. The foyer was observed to be a busy place at this time, with some residents relaxing on couches and armchairs and a receptionist at the main desk, greeting people as they arrived. There was a warm and welcoming atmosphere in the centre and the centres two budgies were seen to be singing and entertaining residents and staff passing. The inspector was met by the person in charge, on arrival at the centre. Following an introductory meeting, the inspector walked through the centre and met with residents and staff.

Carechoice Clonakility provides long term care for both male and female adults with a range of dependencies and needs. The centre is situated in the town of Clonakility, in West Cork. It is a single storey facility, which can accommodate 50 residents and there were 47 residents living in the centre, on the day of this inspection. The centre is divided into three distinct wings, Galley Head, Argideen and Red Strand, all named after local areas in West Cork. Bedroom accommodation comprises 42 single and four twin rooms, all with en-suite facilities. Bedrooms were observed to be personalised with items of significance to each residents such as family photographs and ornaments. Call bells and televisions were provided in all resident bedrooms and there was ample storage space for resident personal possessions.

The design and layout of the centre was suitable for its stated purpose, and met residents' individual and collective needs in a comfortable and homely way. The corridors in the centre were wide and provided adequate space for walking. Handrails were available along all the corridors, to maintain residents' safety and independent mobility. The inspector noted that walls were decorated with art work and ornaments replicating the seaside. Residents were observed mobilising freely throughout the centre during the inspection and there was unrestricted access to two enclosed garden areas which had comfortable seating and colourful plants. Some residents were observed using mobility aids and the inspector noted that residents who required assistance were well supported by staff. There was good access to comfortable communal space throughout the centre which included large sitting room, a dining room, and a sensory room. The inspector noted that resident communal areas were clean, warm and well-furnished. There was an ongoing maintenance programme in place and the premises was in a good state of repair.

Resident's feedback throughout the day provided an insight into the lived experiences in the centre and residents were happy to share their feedback. Residents reported that staff supported them to get up from bed at a time of their choosing, and that they could have a shower when they wished. Residents were familiar with some of the staff who cared for them and this made them feel safe and comfortable in their home. The inspector observed respectful interactions, and a good, personal rapport between staff and residents. Residents were very complimentary about staff saying staff saying that they were very kind, caring and helpful. One resident stated that staff are excellent, they work hard and are always smiling. However, a couple of residents spoken with expressed dissatisfaction with response to their personal care needs when they called for staff, specifically at night. Visitors were observed being welcomed into the centre throughout the inspection. Residents met with their friends and loved ones in their bedrooms or the communal rooms.

A programme of activities was displayed for resident information and the inspector noted that there were two staff allocated to the provision of activities. Several residents informed the inspector that they did not wish to attend activities as they preferred to spend time independently in their bedrooms, and it was evident that their routines and choice were respected. The inspector noted that there was a sociable atmosphere in the centre all day with many activities such as arts and crafts taking place during the day. The inspector saw that the residents of the centre had won a local arts competition run by the local credit union recently which both residents and staff were proud of this achievement. The inspector observed lovely person-centred interactions between activities staff and residents, and it was obvious that staff knew residents well.

The residents dining experience was observed to be a pleasant, sociable and relaxed occasion for residents. The inspector observed residents chatting together, and staff providing discreet and respectful assistance where required. Residents had a choice of meals from a menu that was updated daily. The inspector observed that there was two sittings in the dining room, which facilitated all residents to have their meals in the dining room if they wished. The inspector saw that residents were served pancakes for dessert as it was pancake Tuesday. Residents spoke positively about the food choices and some told the inspector that they had given suggestions and feedback about food choices and menus and they were listened to by the chef.

The next two sections of this report will present findings in relation to governance and management in the centre, and how this impacts on the quality and safety of the service being delivered.

## Capacity and capability

This was an unannounced inspection conducted over one day, to monitor ongoing compliance with the regulations. The last inspection of this centre had been in April 2024. Overall, the findings of this inspection were that Carechoice Clonakility was a

good centre where residents had a good quality of life. However, some actions were required in relation to healthcare and care planning, which are detailed under the relevant regulations.

CareChoice Clonakility is a designated centre for older people, operated by Carechoice Clonakility Limited, who is the registered provider. The designated centre is part of the CareChoice group, who nationally operate 13 other designated centres in Ireland. There was a clearly defined management structure in place, with identified lines of accountability and authority. The organisational structure comprises of a board of directors, a chief executive officer (CEO) and a senior management team. The CEO is the nominated person representing the registered provider. The centre benefits from access to centralised departments, such as human resources (HR), quality and innovation, finance and facilities. The centre was being management daily by an appropriate qualified person in charge. They reported directly to the CEO of the company. There was evidence that the CEO was available to the centre on a daily basis, for consultation and support and they visited the centre in person, to provide oversight and governance support to the management team.

Within the centre the person in charge is supported in their role by an assistant director of nursing, a clinical nurse manager and a team of registered nurses, healthcare attendants, activities, catering, household, and administrative and maintenance staff. There were clear lines of accountability at individual, team and service levels, so that all staff working in the service were aware of their role and responsibilities and to whom they were accountable. A member of staff from the HR department worked in the centre one day per week and was available to support staff recruitment and training. There were communication systems in place, and regular meetings took place with staff and management, in relation to the operation of the service. Meeting records demonstrated that agenda items included the quality and safety of the service, complaints, and safe-guarding. Meeting records detailed the actions agreed and persons responsible.

The registered provider ensured that sufficient resources were available, to ensure the effective delivery of care, in accordance with the statement of purpose, and to meet residents' individual needs. The annual audit schedule indicated regular audits were taking place in areas such as infection control, medication management and care planning. Issues identified for improvement through the audit process were actioned and communicated to staff via meetings and daily briefings. However, further oversight of healthcare was required, to ensure best outcomes for residents, as actioned under regulation 23. A comprehensive annual review of the quality of care had been carried out for 2024, which incorporate feedback from residents and a quality improvement plan for the year ahead.

Management systems were in place to ensure records were maintained in line with regulatory requirements, securely stored, easily retrieved, and made available for inspection. Records were made available to the inspector who noted that they complied with Schedule 2, 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. For example, An Garda Síochána (police) vetting disclosures were in accordance with the National

Vetting Bureau (Children and Vulnerable Persons) Act 2012. A review of staff training records found that all staff had up-to-date mandatory training in fire safety, safeguarding of vulnerable people, and responsive behaviours. Records were seen to be maintained and stored adequately and met legislative requirements.

Incidents occurring in the centre were recorded electronically and there was oversight and monitoring of incidents by the person in charge. All incidents had been reported to the Chief Inspector, as per regulatory requirements. A review of the complaints register found that complaints were recorded, acknowledged, investigated and the outcome communicated to the complainant, in line with the requirements of the regulations.

## Regulation 14: Persons in charge

There was a full-time person in charge employed in the centre with the relevant skills, qualifications and experience to undertake the role. They had been employed as person in charge since November 2021 and had a post registration management qualification.

Judgment: Compliant

## Regulation 15: Staffing

The provider had ensured there were sufficient staffing resources allocated to the centre. From an examination of the staff duty rota and communication with residents and staff it was the found that the levels and skill mix of staff at the time of inspection were sufficient to meet the needs of the 47 residents living in the centre.

Judgment: Compliant

## Regulation 16: Training and staff development

There was an ongoing comprehensive schedule of training in place, to ensure all staff had relevant and up-to-date training to enable them to perform their respective roles. A training matrix was maintained and reviewed by the management team in conjunction with HR support. Staff were supervised in their roles daily by the management team. The provider had good procedures in place for the recruitment and retention of suitable staff. There was a comprehensive induction programme

completed for newly recruited staff which included staff appraisals and probation reviews.

Judgment: Compliant

## Regulation 21: Records

Residents' records were reviewed by the inspector who found that they complied with Schedule 3 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. The records listed in Schedule 4 to be kept in a designated centre were all maintained and made available to the inspector.

Judgment: Compliant

## Regulation 22: Insurance

The provider had an up-to-date contract of insurance in place against injury to residents, and loss or damage to residents' property.

Judgment: Compliant

## Regulation 23: Governance and management

There was evidence that the some management systems in place, were not always effective to ensure adequate oversight of healthcare, to ensure best outcomes for residents, as detailed under regulation 6.

Judgment: Substantially compliant

## Regulation 31: Notification of incidents

A record of incidents occurring in the centre was well maintained. All incidents had been reported in writing to the Chief Inspector, as required under the regulations, within the required time period.

Judgment: Compliant

## Regulation 34: Complaints procedure

A centre-specific complaints policy detailed the procedure in relation to making a complaint and set out the time-line for complaints to be responded to, and the key personnel involved in the management of complaints. The provider ensured that the complaints procedure was accessible and displayed in the centre.

Judgment: Compliant

## Regulation 4: Written policies and procedures

Policies and procedures required by Schedule 5 of the regulations were available to guide staff, for example the policies on use of restraint, safeguarding and end-of-life care. These policies were centre-specific and were up to date with relevant information and national and international guidance.

Judgment: Compliant

## Quality and safety

Overall, this inspection found that residents reported a good quality of life in Carechoice Clonakility where they were supported to maximise their level of independence and their rights were respected. Some actions were required pertaining to healthcare and care planning, as detailed under the relevant regulation.

A pre-admission assessment was completed prior to a resident's admission, to ensure the centre could meet the residents' needs. Residents were assessed using validated tools and care plans were initiated within 48 hours of admission to the centre, in line with regulatory requirements. Care plans reviewed were updated four monthly and some contained detailed information specific to the individual needs of the residents and were sufficiently detailed to direct care. However, some actions were required in care planning, to ensure all information contained was accurate to care delivery, which is further detailed under regulation 5 of this report.

There was evidence of good access to medical care with regular medical reviews by general practitioners and referrals to specialist services as required. Access to West Cork palliative care, community mental health services, dietetics, and speech and language therapists were available. Physiotherapy services were also available

weekly in the centre. There were some aspects of wound care and other aspects of healthcare that required action which required action is further outlined under Regulation 6: Healthcare.

Residents were served food and drinks at regular intervals throughout the day. Meals served were pleasantly presented and residents had menu choices at mealtimes. The person in charge ensured that the menu met the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.

Staff demonstrated an understanding of residents' rights and supported residents to exercise their rights and choice, and the ethos of care was person-centred. Residents' choice was respected and facilitated in the centre. Residents could retire to bed and get up when they choose. Residents said that they were kept informed about changes in the centre through resident forum meetings and daily discussions with staff and felt that their feedback was valued and used to improve the quality of the service.

## Regulation 17: Premises

The centre was homely, warm and welcoming. The layout and design of the premises met residents' individual and collective needs. Residents had free access to two internal courtyards and communal space. The centre was observed to be clean and very well maintained.

Judgment: Compliant

## Regulation 18: Food and nutrition

Residents were offered a varied nutritious diet. The quality and presentation of the meals were of a high standard. Some residents required special diets or modified consistency diets and these needs were provided as recommended. The daily menu was displayed and choice was available at every meal. Residents' feedback was sought with regards to their food in the centre and there was evidence that their suggestions were acted on. For example, residents had requested more fruit be available and the removal of one type of meat and this had been arranged by the catering team.

Judgment: Compliant

## Regulation 5: Individual assessment and care plan

Action was required pertaining to individual assessment and care planning, evidenced by the following:

- A resident whose fluid intake required to be monitored and reviewed daily did not have specific detail in their care plan pertaining to actions to be taken if the fluid intake was below the required amount.
- Residents care plans pertaining to wound care were not accurately maintained.

Judgment: Substantially compliant

## Regulation 6: Health care

Action was required to ensure care delivery was in line with evidence based nursing practice, evidenced by the following findings:

- On review of wound care documentation it was evident that a resident who had been assessed as requiring dressings of their wound every three days, had gaps of four and five days between this dressing being carried out. There was also not timely referral to a tissue viability nurse, for this resident when it was evident that this wound was deteriorating.
- A wound was not graded correctly in line with best practice guidelines.
- The malnutrition universal screening tool (MUST), was used to assess and identify any resident at risk of malnutrition. This incorporated residents at risk being weighed monthly. On a review of a records it was evident that appropriate action was not always taken if a resident had lost weight and some MUST scores were found to be inaccurately calculated.

Judgment: Not compliant

## Regulation 9: Residents' rights

The provider had provided facilities for residents' occupation and recreation and opportunities to participate in activities in accordance with their interests and capacities. Residents expressed their satisfaction with the variety of activities on offer. Residents were provided with the opportunity to be consulted about, and participate in, the organisation of the designated centre by participating in residents meetings and taking part in resident surveys. Residents had access to an independent advocacy service and details regarding this service were advertised on the resident information board, displayed in the reception area of the centre.

| |
|---|
| Judgment: Compliant |

## Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

| Regulation Title | Judgment |
|---|---|
| **Capacity and capability** | |
| Regulation 14: Persons in charge | Compliant |
| Regulation 15: Staffing | Compliant |
| Regulation 16: Training and staff development | Compliant |
| Regulation 21: Records | Compliant |
| Regulation 22: Insurance | Compliant |
| Regulation 23: Governance and management | Substantially compliant |
| Regulation 31: Notification of incidents | Compliant |
| Regulation 34: Complaints procedure | Compliant |
| Regulation 4: Written policies and procedures | Compliant |
| **Quality and safety** | |
| Regulation 17: Premises | Compliant |
| Regulation 18: Food and nutrition | Compliant |
| Regulation 5: Individual assessment and care plan | Substantially compliant |
| Regulation 6: Health care | Not compliant |
| Regulation 9: Residents' rights | Compliant |

# Compliance Plan for CareChoice Clonakilty OSV-0000230

## Inspection ID: MON-0046587

## Date of inspection: 04/03/2025

**Introduction and instruction**
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

## Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

**Compliance plan provider's response:**

| **Regulation Heading** | **Judgment** |
|---|---|
| Regulation 23: Governance and management | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 23: Governance and management:

• The home has a Clinical Governance Committee which oversees continuous quality improvement and clinical risk management. The Committee is comprised of the Person in Charge/DON; the Assistant Director of Nursing, CNM, a registered nurse and a healthcare assistant. The Clinical Governance Committee meet at a minimum every 3 months to review the quality and safety of care and services and to develop action plans for continuous improvement.
• The Governance Department coordinates, monitors, reviews and reports on audits of current practice against standards in any aspect of health care associated with Care of the Older Person in the Nursing Home and includes both clinical and non-clinical audit.
• A full review of wounds and MUST was conducted by DON & Governance Team post HIQA inspection. An action plan was commenced accordingly. This will be monitored by the Clinical Management team.
• The Clinical Management team monitors and reviews KPI's weekly and monthly. Clinical reports are monitored to ensure that the care provided to residents is safe, and appropriate.
• Ongoing auditing of assessments and care plans continue to be monitored by the clinical management team to ensure the healthcare provided to residents is assessed, documented and provided appropriately in line with the residents' care plan.
• All residents' assessments and care plans are reviewed at a minimum of 4 monthly or when the residents' condition alters and this includes oral hygiene, skin integrity, and nutrition.
• The clinical management team review wounds and related documentation on a weekly basis to ensure that all wounds are reviewed appropriately and timely.
• Nursing staff have received further training in the use of the malnutrition universal screening tool to include accurate calculation of weight loss percentage. The clinical management team perform spot checks weekly to ensure accuracy and compliance in follow-up guidance, alongside local policy.

| |
|---|
| • Within the above, greater emphasis will be placed on wound care documentation, wound categorization, timely referral to MDT services, review of assessment and careplan documentation. |

| | |
|---|---|
| Regulation 5: Individual assessment and care plan | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:

• The clinical management team will continue to complete care plan audits each month to ensure that they are personalized, updated and meet the requirements. Each nurse will be provided with feedback from the audit with support and supervision provided as part of follow up.
• Nurses have been provided with a care plan and assessment toolkit that will further assist them in accurate completion.
• The resident identified on the day of inspection, who required their fluid intake to be monitored and reviewed daily, has a care plan that identifies the actions to be taken should their fluid intake be below the GP recommendation, over a 24-hour period.
• Care staff record fluid intake for all residents in the home. Nursing staff complete a review of all residents' fluid balance during their duty and document their findings in each resident's daily progress notes. Any changes are discussed at handover and safety huddles. A member of the clinical management team attends handover and safety huddles daily.
• The clinical management team run a fluid report daily and disseminate this information at daily handover and safety huddles. Any noted deficits are cross checked against care plans and medical reviews.
• All wound care plans have been reviewed by the clinical management team to ensure accuracy of wound description, dressing type and frequency of dressing change. TVN reviews and interventions have been applied to relevant care plans. Nursing staff have been educated in completion of care plan review following each dressing change.
• The clinical management team complete a review of all wounds weekly, including assessments, photography, MDT reviews and care plans. Any identified gaps are addressed with nursing staff and updated.

| | |
|---|---|
| Regulation 6: Health care | Not Compliant |

Outline how you are going to come into compliance with Regulation 6: Health care:

• All residents' healthcare needs are discussed at the staff handovers x 2 per day. The team also complete safety huddles during the day to review any changes to residents or any identified deterioration or risk. The care provided to the residents is assessed by the nursing team and recorded in the daily progress notes.
• The resident identified on the day of inspection, who had been assessed as requiring wound care every three days, but had gaps of four and five days, has been reviewed by the TVN. The dressing type is unchanged, nurses review these every three days. Wound KPI's are reviewed weekly by the ADON. A site report is completed monthly by the DON. The clinical management team completes a review of all wounds weekly. Braden and top to toe assessments have been reviewed to ensure they reflect the residents risk and current skin integrity. Spot checks completed against assessments, care plans and preventative measures applied. All staff have reviewed and acknowledged wound management policy, to promote best practice in skin care and wound management for individual residents in CareChoice.
• A wound that was not graded correctly in line with best practice has been reviewed. An error in the reporting system used, has been identified and this has now been addressed.
• All current wounds have been reviewed to ensure that they are correctly categorized, referred to TVN as required, and dressings are completed as per TVN recommendations. Referral for TVN review is available through the electronic care management system. Nurses have been guided in use of this and timely follow up. The ADON reviews all referrals weekly to ensure timely intervention.
• Nurses are guided in effective management of all wounds by the clinical management team. Wound training, by a TVN, in relation to pressure ulcers and MASD has been completed by nursing and healthcare staff.
• All residents' nutrition and weight are assessed, completing the monthly MUST assessment. The nursing team are aware of discussing any changes in the residents' assessment with the clinical management team and the GP as appropriate. The ADON reviews the residents with a MUST score of concern to ensure that the MUST score is calculated correctly and is recorded in the careplan. Where appropriate the resident is referred to the dietician and their recommendations are included in the careplan. All staff are aware of the recommendations, and these are communicated to the catering team to ensure the appropriate diet is available to the resident.
• The DON ensures that all assessments and care plans reflect the resident needs in completing a robust auditing schedule and the results of the audits are discussed with the nursing team.

## Section 2:

## Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

| Regulation | Regulatory requirement | Judgment | Risk rating | Date to be complied with |
|---|---|---|---|---|
| Regulation 23(c) | The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored. | Substantially Compliant | Yellow | 04/04/2025 |
| Regulation 5(4) | The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family. | Substantially Compliant | Yellow | 06/03/2025 |
| Regulation 6(1) | The registered provider shall, having regard to | Not Compliant | Orange | 04/04/2025 |

| | | | | |
|---|---|---|---|---|
| | the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident. | | | |